U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 20 December 2005

In The Matter Of:
ANDY J. ADKINS
Claimant

v. 2005-BLA-05130

KEY MINING
Employer/Carrier

And

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR
Party-in-Interest

Appearances:

Christy Hutson, Lay Representative
For the Claimant

Natalee A. Gilmore, Esquire
For the Employer

Before: Daniel F. Solomon
Administrative Law Judge

DECISION AND ORDER

DENIAL of BENEFITS

This case arises from a claim for benefits under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §901 et seq. (hereinafter referred to as "the Act"), and applicable federal regulations, mainly 20 C.F.R. Parts 410, 718 and 727 ("Regulations").

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as black lung.[1]

[1] The following abbreviations have been used in this opinion: DX = Director's exhibit, EX = Employer's exhibit, CX = Claimant's exhibit, TR = Transcript of the hearing, BCR = Board-certified radiologist, BCI = Board-certified internist, and B = B reader.

A formal hearing was conducted in Knoxville, Tennessee on May 18, 2005 at which all parties were afforded a full opportunity to present evidence and argument, as provided in the Act and Regulations issued thereunder, found in Title 20, Code of Federal Regulations.[2]

ISSUES

The contested issues are:

1. Whether Claimant has established a material change of condition pursuant to §725.309;
2. Whether Claimant has pneumoconiosis;
3. Whether Claimant's pneumoconiosis was caused by his coal mine employment;
4. Whether Claimant has a totally disabling respiratory impairment; and
5. Whether the total disability was due to pneumoconiosis.

TR 7.

STIPULATIONS

Pursuant to 20 CFR § 725.461(a), which sets forth in pertinent part, "…stipulations shall be considered the evidence of record in the case and the decision shall be based upon such evidence," the parties have agreed to the following:

1. The parties stipulated and I find that Claimant was a coal miner, within the meaning of the Act, for 15 years. TR 7.
2. The parties stipulated and I find the evidence of record supports the conclusion that Key Mining is the properly named responsible operator in this case. TR 7.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History and Factual Background[3]

Claimant, Andy J. Adkins filed his first claim for Black Lung benefits on April 11, 1994. DX 1. The claims examiner subsequently denied Claimant's claim because he failed to establish the existence of pneumoconiosis and that he was totally disabled by pneumoconiosis. No further action was taken on this claim and it was subsequently closed. DX 1.

Claimant filed his second claim for benefits on May 2, 2002. DX 2. On October 21, 2003, the district director issued a Proposed Decision and Order allowing withdrawal of the second claim. DX 2.

Claimant filed his third claim for benefits on November 14, 2003. DX 4. On August 3, 2004, the district director issued a Proposed Decision and Order- Awarding Benefits. DX 22.

[2] At the hearing, Director's exhibits 1 through 29 were admitted into evidence. TR 6. Claimant's exhibits 1 and 2 were identified for the record and are hereby admitted into evidence. TR 10-12. Employer's exhibits 1 through 3 and 5 through 8 were admitted into evidence. Employer's exhibit 4 was comprised of x-ray interpretations by Dr. Wheeler of chest x-rays contained within the treatment records. I ruled at the hearing that these additional chest x-rays were inadmissible as being excessive under the amended regulations. Employer's exhibits 9 and 10 were admitted only for purposes of appeal. TR 25-42.

[3] Mr. Atkins' most recent coal mine employment was with Key Mining at its mines in Tennessee, and therefore, the rulings of the U.S. Court of Appeals for the Sixth Circuit control this case. *See* ***Kopp v. Director, OWCP***, 877 F.2d 307 (4th Cir. 1989).

Employer disagreed with the decision and requested a formal hearing. DX 23. The claim was transferred to the Office of Administrative Law Judges on October 25, 2004. DX 26.

At the hearing, Claimant testified that he worked 18 years in the coal mine industry. TR 14. Claimant stated that he hauled coal to the tipple and was exposed to coal mine dust. TR 14-15. When he worked underground, his jobs included timbering, running a Wilcox miner at the face of the mine, and running a shuttle car. TR 15-16. He added that he would sometimes wear a respirator. TR 16. Claimant testified that he had never been diagnosed with tuberculosis. TR 17. He noted that Drs. Mitchell and Hughes told him he had black lung disease. TR 18. Dr. Hughes was Claimant's treating physician and pulmonologist for the last 3-4 years. TR 18. Claimant stated that he had difficulty breathing at night and that he had to sleep mostly in a chair. TR 19. Claimant could mow the lawn with a riding mower and still hunted using a four wheeler. TR 19. Claimant noted that he smoked about 1 ½ packs per day ending 30 years ago. TR 20.

On cross-examination, Claimant stated that he was probably in his teens when he started smoking. TR 21. He added that he had been married to his wife, Shirley for 47 years. TR 21. Claimant agreed that he stopped working because they shut the mine down. TR 21. Claimant noted he has been treated for colon cancer. TR 22.

Claimant additionally testified that he left mining in 1991. TR 23. He noted that his breathing has gotten a lot worse since 2002 and that he could hardly get his breath. TR 24.

Medical Evidence

The following is a summary of the medical evidence submitted in conjunction with Claimant's most recent claim for benefits. The parties have designated this evidence in conformance with the medical evidence limitations promulgated under the amended regulations to the Act.

Chest X-rays

Exhibit Number	Date of X-ray	Physician/Qualifications	Diagnosis
EX 2	8-21-03	Jarboe/ B	Negative for CWP
DX 12[4]	11-3-03	Miller/BCR,B	Complicated pneumoconiosis, 2/3, t/s, Cat. B
DX 20	11-3-03	Wheeler/ BCR,B	Negative for CWP
DX 11	1-22-04	Baker/ B	Complicated pneumoconiosis, 1/0, t/t, Cat. A
DX 11	1-22-04	Barrett/ BCR, B	Film Quality 1
DX 20	1-22-04	Wheeler/ BCR, B	Negative for CWP
DX 13	2-9-04	Dahhan/ B	Negative for CWP
DX 21	2-9-04	Ahmed/ BCR, B	Complicated pneumoconiosis, 2/1, t/u, Cat. A

[4] The exhibit number for the x-ray interpretation by Dr. Miller was incorrectly identified in Claimant's pre-hearing report and at the hearing as DX 21. This document actually appears at DX 12 of the record.

Pulmonary Function Studies[5]

Exhibit	Date	Age	Height	FEV 1	MVV	FVC	Qualify
EX 2	8-21-03	68	164 cm (64.57")	1.62 *1.66	61 *52	2.56 *2.51	No No
DX 11	1-22-04	68	64"	1.72	64	2.71	No
DX 13	2-9-04	68	165 cm (64.96")	1.88 *1.91	37 *32	2.83 *2.93	No No

*post-bronchodilator

Arterial Blood Gas Studies

Exhibit	Date	PO2	PCO2	Qualify
EX 2	8-21-03	75.7	39.8	No
DX 11	1-22-04	84	41	No
DX 13	2-9-04	78.8 *73.8	45.2 40.3	No No
DX 21	5-3-04	58.9	36.5	Yes

*post-exercise

Medical Reports

Dr. Thomas Jarboe

The medical report of Dr. Jarboe is dated August 28, 2003 and appears at EX 2. Dr. Jarboe is Board-Certified in Internal Medicine and Pulmonary Disease and is a B-reader of chest x-rays. He examined Claimant on August 21, 2003. Dr. Jarboe also reviewed and summarized some additional medical records. He reviewed Claimant's occupational history noting 18 years of underground coal mine employment. Claimant jobs included running a shuttle car and scoop. Claimant also drove a coal truck. Claimant's chief complaints were shortness of breath, cough with sputum, and some wheezing. Claimant reported a smoking history of 1 ½ packs per day from age 15 to age 45 or a 45 pack year smoking history. Physical examination of the lungs revealed rare crackles at the right base and intense showers of fine crackles at the left base. A chest x-ray was read as negative for pneumoconiosis but showed diffuse pleural thickening bilaterally with calcification due to remote infectious disease such as TB or bilateral empyema or asbestos disease. Dr. Jarboe added that he did not feel the apical densities represented complicated pneumoconiosis because there was no background of small rounded opacities. He opined that these densities may represent old scars. Spirometry showed a mild restriction and obstruction with no response to bronchodilators. He noted that the diffusion capacity was severely lowered. The resting arterial blood gases were normal.

Dr. Jarboe concluded there was insufficient medical evidence to make a diagnosis of simple coal worker's pneumoconiosis. He noted that the predominant feature of the x-rays was extensive bilateral calcified pleural disease with no rounded opacities to suggest coal worker's disease. Moreover, he pointed out that CWP did not usually cause fine crackles. Dr. Jarboe concluded Claimant had a significant pulmonary impairment based at least in part on a severely reduced diffusing capacity. He opined that this impairment was due to extensive pleural disease, probable bullous emphysema caused by cigarette smoke, and interstitial lung disease of undetermined etiology. He stated that he did not feel that coal dust inhalation caused these

[5] Due to the discrepancy in height, qualification of the vent studies is based on an average height of 64.51 inches.

changes. Dr. Jarboe concluded that Claimant was totally disabled from a respiratory standpoint from performing his regular coal mine employment. He added that he found no disease of the respiratory system which had been caused by or substantially contributed to by the inhalation of coal dust or the presence of coal worker's pneumoconiosis.

The deposition of Dr. Jarboe was taken on April 21, 2005 and appears at EX 6. A representative for Claimant was not present for the deposition. Prior to the deposition, Dr. Jarboe reviewed additional medical evidence including the medical reports of Drs. Dahhan and Baker, various chest x-rays and four CT scan reports. After reviewing additional pulmonary function studies and arterial blood gas studies, Dr. Jarboe stated that Claimant had a mild restriction and mild obstruction. He added that Dr. Dahhan's vent study only showed a mildly reduced diffusion capacity. He noted that the arterial blood gases were essentially normal with a drop after exercise. Dr. Jarboe concluded Claimant did not have medical or legal pneumoconiosis as defined by the Act. He based his opinion on the fact that the bullous emphysema was more likely due to Claimant's 45 pack year history of smoking and the restrictive impairment was most likely due to old scarring. He noted that coal dust inhalation did not cause pleural disease, calcified plaques, or pleural plaques. Dr. Jarboe concluded that Claimant did not have any respiratory disability caused by, related to, or substantially aggravated by coal dust exposure.

Dr. Glen Baker

The medical report of Dr. Glen Baker appears at DX 11 and is dated January 22, 2004. Dr. Baker is Board-Certified in Internal Medicine and Pulmonary Disease and is a B-reader of chest x-rays. Dr. Baker conducted his examination of Claimant on behalf of the Department of Labor. He reviewed Claimant's occupational history noting 18 ½ years of underground coal mine employment. Claimant's last position was as a shuttle car operator. Claimant reported a family history of heart disease and diabetes. Claimant had a medical history of pneumonia, chronic bronchitis, and arthritis. Dr. Baker noted a smoking history of 1- 1 ½ packs per day for 20+ years ending 20 + years ago. Claimant's chief complaints were cough with sputum production, dyspnea, and orthopnea. Physical examination was unremarkable. A chest x-ray was read as showing coal worker's pneumoconiosis ("CWP"), 1/0, with progressive massive fibrosis. A vent study showed a mild obstructive defect and the arterial blood gases were within normal limits. Dr. Baker diagnosed Claimant as having CWP with progressive massive fibrosis due to coal mine dust exposure based on abnormal chest x-ray and coal mine employment history. He also diagnosed chronic bronchitis due to coal mine dust exposure and cigarette smoking based on history, and COPD with mild obstructive defect due to coal mine dust exposure and cigarette smoking based on pulmonary function tests. Dr. Baker concluded Claimant had a mild impairment due to decreased FEV-1, chronic bronchitis, and CWP.

The deposition of Dr. Baker was taken on April 21, 2005 and appears at EX 5. A representative for Claimant was not present for the deposition. He noted that based on the pulmonary function studies, Claimant had a mild obstructive impairment that would not be totally disabling and would only be a Class 2 impairment based on textbook guidelines. Dr. Baker stated that the "A" opacity he saw on the chest x-ray could have been a cancer or a scar from pneumonia, TB, a fungal infection, or other infectious process. He added that "A" opacities were seen with a background of heavy pneumoconiosis. Dr. Baker stated that his x-ray "could be" consistent with a diagnosis of complicated pneumoconiosis but that it may not be.

Dr. A. Dahhan

The medical report of Dr. Dahhan is dated February 17, 2004 and appears at DX 13. Dr. Dahhan is Board-Certified in Internal Medicine and Pulmonary Disease and is a B-reader of chest x-rays. Dr. Dahhan examined Claimant at the request of Employer on February 9, 2004. He noted an occupational history of 18 ½ years of coal mine employment. He added that all of his employment was underground operating a scoop and shuttle car. Claimant smoked 1 ½ packs of cigarettes per day from age 20 to age 43. Claimant had a history of cough with sputum and dyspnea on exertion. Physical examination was unremarkable. Exercise arterial blood gases showed minimal hypoxemia, spirometry showed a mild obstructive defect with no significant response to bronchodilators, and a chest x-ray showed pleural thickening with no evidence of pneumoconiosis. Based on the occupational, clinical, radiological, and physiological evaluation, Dr. Dahhan diagnosed Claimant as having pleural abnormalities on chest x-ray not consistent with pneumoconiosis, and a mild obstructive defect. Dr. Dahhan opined that from a respiratory standpoint, Claimant maintained the pulmonary capacity to perform his last coal mine employment. In addition, Claimant had no evidence of a pulmonary impairment caused by, related to, contributed to or aggravated by the inhalation of coal mine dust or coal worker's pneumoconiosis.

The deposition of Dr. Dahhan was taken on May 16, 2005 and appears at EX 7. A representative of Claimant was not present at the deposition. Dr. Dahhan reviewed additional medical reports before his deposition including x-ray interpretations, CT scan reports, and medical reports from Drs. Jarboe and Baker. Dr. Dahhan stated that based on the vent studies of record that Claimant had a mild obstructive defect due to smoking. He opined that Claimant's pulmonary impairment was not disabling based on the FEV 1, FVC, and blood gas values. He attributed the obstructive impairment to smoking because it was responsive to bronchodilator therapy. If Claimant had pneumoconiosis, the obstructive defect would be fixed. Dr. Dahhan also concluded Claimant had no significant abnormality in his ability to oxygenate his blood. Dr. Dahhan concluded Claimant did not have pneumoconiosis based on clinical examinations, pulmonary function studies, arterial blood gases, CT scans, and chest x-rays. He added that Claimant did not have legal pneumoconiosis and was not totally disabled from a respiratory impairment. Dr. Dahhan stated that PET scans were more limited to the diagnosis of cancer and metastases and was not used to diagnose or assess the presence of CWP or other occupationally acquired lung diseases.

Other Medical Evidence

CT Scans

Exhibit Number	Date of CT Scan	Physician/Qualifications	Diagnosis
EX 1	8-29-02	Wheeler/ BCR, B	No CWP; moderate COPD, probable healed TB, moderately large calcified benign asbestos-related pleural plaque on right lateral chest wall, 2 small

			calcified granulomata in RLL, no diffuse bilateral interstitial fibrosis to suggest asbestosis
EX 3	8-29-02	Scott/ BCR, B	Moderate bullous emphysema, pleural calcification on the right, scattered calcified granulomata, changes compatible w/ at least partially healed TB
EX 3	5-26-04	Wheeler/ BCR, B	No CWP; small mass LUL compatible w/healed pneumonia, probably TB, moderate emphysema, few scattered calcified granulomata compatible w/ healed TB or histoplasmosis, long sheet like pleural plaque compatible w/ asbestos exposure or healed TB
EX 3	5-26-04	Scott/ BCR, B	Severe bullous emphysema, focal scarring, scattered calcified granulomata, pleural calcification on the right, changes compatible w/healed TB

PET Scan

A whole body PET scan taken on November 16, 2004 was submitted into evidence and appears at CX 2. The PET scan was performed by Dr. Hejung Press for the purposes of initial

staging of Claimant's colon cancer. It was noted that the appearance in the chest was suspicious for an inflammatory process such as progressive massive fibrosis or pneumoconiosis. It was also noted that Claimant had pleural based calcifications consistent with chronic lung disease.

Deposition of Dr. Paul Wheeler

The deposition of Dr. Wheeler was taken on May 11, 2005 and appears at EX 8. A representative for Claimant was not present for the deposition. This deposition was offered by Employer as "other medical evidence" and as rebuttal to the PET scan offered by Claimant. Only those portions of the deposition that deal with CT scans or the PET scan will be considered.

Dr. Wheeler is Board-Certified in Radiology and is a B-reader of chest x-rays. He testified that CT Scans were very good technique for determining the presence or absence of complicated pneumoconiosis. CT Scans pick up masses but also confirm the background nodularity and they show any calcifications that might be within the masses that would tend to favor healed granulomatous diseases such as TB or histoplasmosis. In his opinion the CT scans that he reviewed in this case did not demonstrate any evidence of coal dust related lung disease. Dr. Wheeler discussed the PET scan and indicated that it would not change his opinion regarding the presence or absence of complicated pneumoconiosis in this case. Dr. Wheeler noted that PET scans were typically used for diagnosing cancer and not detecting the presence of pneumoconiosis.

Treatment Records of Dr. Fritz Fielder

The treatment records of Dr. Fielder are part of the record. CX 1. It was noted in the 4-20-94 exam note that Claimant had "significant" black lung disease.

Also, as part of Claimant's exhibit 1 is a consultation report, dated February 27, 1994, by Dr. James Michel is part of the record. Dr. Michel indicated Claimant was suffering from biliary tract obstructions due to cholelithiasis. A physical examination of the chest revealed bibasilar rales and a chest x-ray was still pending to rule out congestive heart failure. On 2-28-94, Claimant underwent a laparoscopic cholecystectomy. The discharge summary from Methodist Medical Center dated March 4, 1994 indicated that Claimant had some dyspnea on exertion due to black lung disease. He was discharged with a diagnosis of acute cholecystitis with gallstones, biliary pancreatitis, and black lung disease.

Treatment Records of Dr. John Burrell

The treatment records from 8-28-02 through 12-9-03 of Dr. Burrell appear at DX 21. Dr. Burrell is Board-Certified in Family Practice. At his first visit on 8-28-02 it was noted Claimant had a history of COPD with emphysema and probable pneumoconiosis. It was noted on 9-12-02 that Claimant had CT scan that showed changes consistent with asbestos exposure. Claimant was referred to Dr. Hughes for further evaluation. The last note, dated 12-9-03, indicated Claimant had a history of CWP, silicosis with progressive massive fibrosis, and asbestos related pleural disease. He stated that the 11-10-03 x-rays showed changes suggestive of pneumoconiosis then later stated, "In spite of Dr. Hughes effort and the obvious x-ray findings of pneumoconiosis the patient has been turned down for his black lung benefits."

Treatment Records of Dr. R. Hal Hughes

The treatment records of Dr. Hughes appear at DX 21. Dr. Hughes is Board-Certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine. He issued a medical note on

July 29, 2002 addressed to Dr. Burrell. He stated that Claimant had classic radiographic changes consistent with coal dust and silicosis. He added that Claimant would benefit from a chest CT scan to rule out the presence of cancer. In a note dated 8-23-03, Dr. Hughes noted that Claimant had CWP with silicosis and progressive massive fibrosis, asbestos-related pleura disease, and significant dyspnea with airflow obstruction. Dr. Hughes noted he was seeing Claimant once per year to monitor his pulmonary condition.

Consultation Report of Dr. Charles Bruton

The consultation report of Dr. Bruton is dated March 4, 1994 and appears at DX 21. Claimant was hospitalized at Methodist Medical Center on February 24, 1994 for treatment of gallstone pancreatitis. Dr. Bruton was asked to evaluate Claimant for an increased AA gradient. Physical examination of the lungs showed rales at both bases. He concluded that Claimant's increased shortness of breath was related to his coal worker's pneumoconiosis. He noted that the chest x-ray showed increased interstitial markings and pleural changes.

Conclusions of Law

Burden of Proof

"Burden of proof," as used in this setting and under the Administrative Procedure Act[6] is that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof". "Burden of proof" means burden of persuasion, not merely burden of production. 5 U.S.C.A. § 556(d).[7] The drafters of the APA used the term "burden of proof" to mean the burden of persuasion. ***Director, OWCP, Department of Labor v. Greenwich Collieries*** [Ondecko], 512 U.S. 267, 114 S.Ct. 2251 (1994).[8]

A claimant has the general burden of establishing entitlement *and* the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition, not simply the burden of production, the obligation to come forward with evidence to support a claim.[9] Therefore, the claimant cannot rely on the Director to gather evidence.[10] A claimant, bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP***, 7 BLR 1-860 (1985).

The amended regulations make clear that the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. § 725.309(d)(2). In the denial of the miner's first claim, it was found that:

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[6] 33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, any hearing held under this chapter shall be conducted in accordance with [the APA]"); 5 U.S.C. § 554(c)(2). Longshore and Harbor Workers' Compensation Act ("LHWCA"), 33 U.S.C. §§ 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. §§ 932(a).

[7] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 BLR 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v. Director, OWCP*** [*Sainz*], 748 F.2d 1426, 7 BLR 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption is triggered, and the burden of proof shifted from a claimant to an employer/carrier.

[8] Also known as the risk of nonpersuasion, see 9 J. Wigmore, ***Evidence*** § 2486 (J. Chadbourn rev.1981).

[9] ***Id***, *also see* ***White v. Director, OWCP***, 6 BLR 1-368 (1983)

[10] ***Id***.

Subsequent Claims

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim; see 20 C.F.R. §725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a subsequent claim which will be denied on the basis of the prior denial unless the claimant demonstrates that one of the applicable conditions of entitlement has changes since the date upon which the order denying the prior claim became final. § 725.309(d) (2001). Under this regulatory provision, according to the Court of Appeals for the Sixth Circuit in ***Sharondale Corp. v. Ross***, 42 F.3d 993, 997-998 (6th Circuit 1994):

> [T]o assess whether a material change is established, the ALJ must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then, the ALJ must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

I interpret the *Sharondale* approach to mean that the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of an element of entitlement. The court in ***Peabody Coal Company v. Spese***, 117 F.3d 1001, 1008 (7th Circuit 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

Entitlement: In General

To establish entitlement to benefits, a claimant must establish that he had pneumoconiosis, that his pneumoconiosis arose out of coal mine employment, that claimant was totally disabled, and that his total disability was due to pneumoconiosis.

In his previous two claims for benefits, Claimant did not establish any element of entitlement. DX 1, DX 2. Therefore, I will evaluate the newly submitted evidence to determine whether Claimant has established a material change in conditions. If Claimant is able to establish such a change, I will then conduct a denovo review of the evidence to determine whether Claimant is entitled to benefits.

Determination of Pneumoconiosis

30 U.S.C. § 902(b) and 20 C.F.R. § 718.201 define pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." [11] The definition is not confined to "coal workers'

[11] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. ***Mullins Coal Co. v. Director, OWCP,*** 484 U.S. 135, 151 (1987); ***Lisa Lee Mines v. Director***, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at

pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis.[12] 20 C.F.R. § 718.201. The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

The claimant has the burden of proving the existence of pneumoconiosis by any one of four methods. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrefutable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a). Pulmonary function studies are not diagnostic of the presence or absence of pneumoconiosis. ***Burke v. Director, OWCP***, 3 B.L.R. 1-410 (1981).

Chest X-ray Evidence

A finding of the existence of pneumoconiosis may be made with positive chest x-ray evidence. 20 C.F.R. § 718.202(a)(1). The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). Where two or more x-ray reports are in conflict, the radiologic qualifications of the physicians interpreting the x-rays must be considered. §718.201(a)(1).

While a judge is not required to defer to the numerical superiority of x-ray evidence, although it is within his or her discretion to do so. ***Wilt v. Woverine Mining Co.***, 14 B.L.R. 1-70 (1990) citing ***Edmiston v. F & R Coal,*** 14 B.L.R. 1-65 (1990). The ALJ must rely on the

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1364; ***LaBelle Processing Co. v. Swarrow***, 72 F.3d 308 (3d Cir. 1995) at 314-315.

[12] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

evidence which he deems to be most probative, even where it is contrary to the numerical majority. ***Tokarcik v. Consolidation Coal Co.***, 6 B.L.R. 1-666 (1984).

In summary, there are eight (8) interpretations of four (4) x-rays that have been submitted as part of Claimant's current claim for benefits. The Benefits Review Board has held that it is proper to credit the interpretation of a dually qualified physician over the interpretation of a B-reader. ***Cranor v. Peabody Coal Co.***, 22 B.L.R. 1-1 (1999). (en banc on recon.). There are five (5) interpretations by dually qualified Board-Certified Radiologists and B-readers in this case. Two (2) of the interpretations were negative for pneumoconiosis, two (2) interpretations were positive for pneumoconiosis, and one (1) interpretation was for film quality only. Accordingly, since the x-ray evidence is at best equivocal for the presence of pneumoconiosis, I find that Claimant has failed to establish, by the preponderance of the newly submitted evidence, the existence of pneumoconiosis pursuant to §718.202(a)(1).

Biopsy Evidence

Pursuant to §718.202(a)(2) Claimant may establish pneumoconiosis through the use of biopsy evidence. Since no such evidence was submitted, it is clear that pneumoconiosis has not been established in this manner.

The Presumptions

Under §718.202(a)(3) it shall be presumed that a miner is suffering from pneumoconiosis if the presumptions provided in §§718.304, 718.305, or 718.306 apply.

Initially, I note that Claimant cannot qualify for the §718.305 presumption because he did not file this claim before January 1, 1982. Claimant is also ineligible for the §718.306 presumption because he is still living.

The third presumption involves the existence of complicated pneumoconiosis. §718.304. Complicated pneumoconiosis is established by x-rays classified as Category A, B, C, or by an autopsy or biopsy that yields evidence of massive lesions in the lung.

Of the newly submitted evidence, there are four chest x-ray interpretations by dually-qualified radiologists in the record. ***Cranor v. Peabody Coal Co., supra***. Two of the interpretations were positive for the presence of complicated pneumoconiosis and two of the interpretations were negative. Accordingly, based on the chest x-ray evidence, Claimant has failed to establish, by the preponderance of the evidence, the existence of complicated pneumoconiosis.

In addition, the record contains the medical reports of Drs. Jarboe, Baker, and Dahhan. Of the three, only Dr. Baker made a diagnosis of progressive massive fibrosis. I find that Dr. Baker's opinion is not well-reasoned and is not well-documented. He made the diagnosis of progressive massive fibrosis based on his review of the chest x-ray taken on 1-22-04. However this x-ray was read by Dr. Wheeler, a Board-Certified Radiologist and B-reader, as negative for complicated pneumoconiosis. Moreover, I find Dr. Baker's opinion to be equivocal. At his deposition, Dr. Baker stated that the "A" opacity he identified on the chest x-ray could have been a cancer or a scar from pneumonia, TB, or fungal infection. He also testified that the x-ray "could be" consistent with a diagnosis of complicated pneumoconiosis but that it may not be. Based on the foregoing, I find the opinion of Dr. Baker unpersuasive and thereby accord his opinion less weight on this issue.

Claimant submitted a Positron Emission Tomography, "PET" scan taken on 11-16-04 in support of his claim. CX 2. Dr. Press read the scan as "suspicious" for an inflammatory process

such as progressive massive fibrosis or pneumoconiosis. The Regulations require that the party who submits "other medical evidence," such as a PET scan, in conjunction with a claim has the burden to demonstrate that the test or procedure is (1) medically acceptable and (2) relevant to establishing or refuting a claimant's claim for benefits. §718.107(b). Accordingly, the burden is on Claimant to establish that a PET scan is medically acceptable and that it is relevant to establishing his claim for benefits.

I find that Claimant has not submitted any evidence demonstrating that a PET scan is medically acceptable or that it is a relevant diagnostic tool in diagnosing pneumoconiosis. In fact, Drs. Wheeler and Dahhan questioned the use of a PET scan in detecting the presence of pneumoconiosis and testified at their depositions that PET scans were typically used to diagnose and stage cancers and was not used as a diagnostic tool in assessing the presence of pneumoconiosis. For these reasons, I accord less weight to the PET scan submitted by Claimant.

Also of record are four CT scan reports. Like a PET scan, CT scan evidence is considered "other medical evidence" under the Regulations. As such, the party offering the CT scans must demonstrate the procedure is (1) medically acceptable and (2) relevant to establishing or refuting a claimant's claim for benefits. §718.107(b). Employer offered all four CT scans into evidence, therefore it is Employer's burden to establish the elements outlined under §718.107(b). ***see Tapley v, Bethenergy Mines, Inc.***, BRB NO. 04-0790 BLA (May 26, 2005)(unpubl.).

Employer submitted the deposition testimony of the highly qualified radiologist, Dr. Wheeler. EX 8. Dr. Wheeler testified that CT scans were a very good technique for determining the presence or absence of complicated pneumoconiosis. He also noted that CT scans picked up masses but also confirmed background nodularity necessary to a diagnosis of complicated pneumoconiosis. There is no contrary evidence in the record. I find based on Dr. Wheeler's testimony that Employer has satisfied the requirements at §718.107(b).

Each CT scan was read by a Board-Certified Radiologist and B-reader. None of the reports mention a finding of complicated pneumoconiosis or progressive massive fibrosis. There is no contrary CT scan evidence in the record.

Lastly, the record contains the treatment records of Drs. Burrell (DX 21) and Hughes (DX 21). Both indicate that Claimant had a history of progressive massive fibrosis but do not give any basis for their conclusions. Because their reports only contain conclusions with no supporting rationale, I accord these opinions less weight.

Based on the foregoing, I conclude Claimant has failed to establish the presence of complicated pneumoconiosis pursuant to §718.304.

In conclusion, because none of the presumptions are applicable in this case, it is clear Claimant has failed to establish the existence of pneumoconiosis pursuant to §718.202(a)(3).

Medical Opinions

Lastly, under §718.202(a)(4) a finding of pneumoconiosis may be based on the opinion of a physician, exercising sound medical judgment, who concludes that the miner suffers or suffered from pneumoconiosis. Such conclusion must be based on objective medical evidence and must be supported by a reasoned medical opinion.

Smoking History

In general, in order for physicians to arrive at a proper, reasoned diagnosis, it is essential that they be presented with an accurate picture of a patient's complaints, prior medical history, working or environmental conditions, and social habits, including smoking. ***See Stark v.***

Director, OWCP, 9 B.L.R. 1-36 (1986) (An opinion may be given less weight where the physician did not have a complete picture of the miner's condition.).

Specifically, in Black Lung cases, a claimant's smoking history is of particular importance. This is because the pulmonary manifestations of smoking are often similar to that of coal workers' pneumoconiosis.

I find that Claimant consistently reported a smoking history of about 1½ packs of cigarettes per day from age 15 to age 45 for a 30 to 45 pack year smoking history.

Analysis of Medical Opinions

There are three (3) physicians that have rendered an opinion in this matter. Dr. Baker concluded Claimant had radiographic evidence of clinical pneumoconiosis. Whereas Drs. Dahhan and Jarboe concluded there was no radiographic evidence of clinical pneumoconiosis. All three physicians agreed that Claimant suffered from some type of bilateral pleural disease but disagreed as to the cause. Dr. Jarboe opined Claimant had bullous emphysema caused by cigarette smoking and interstitial lung disease of unknown etiology. Dr. Baker opined Claimant had chronic bronchitis and COPD due to cigarette smoking and coal mine dust exposure. Dr. Dahhan concluded Claimant did not have legal pneumoconiosis and that his obstructive impairment was fixed and due to cigarette smoking.

I first note that Drs. Dahhan, Baker, and Jarboe are highly qualified physicians who have excellent credentials. All three are Board-Certified in Internal Medicine and Pulmonary Disease. Accordingly, I find Drs. Dahhan, Baker, and Jarboe to be highly qualified to render an opinion in this matter. ***Burns v. Director, OWCP***, 7 B.L.R. 1-597 (1984).

I accord less weight to the opinion of Dr. Baker on this issue. I find that his opinion was not well-reasoned and not consistent with the objective evidence of record. In particular Dr. Baker concluded, contrary to the findings of this opinion, that Claimant had radiographic evidence of pneumoconiosis (clinical pneumoconiosis). As noted previously, I found that the more credible x-ray evidence was at best, equivocal, for the presence of pneumoconiosis. I also accord less weight to Dr. Baker's opinion that Claimant suffered from chronic bronchitis and COPD due to coal mine dust and smoking (legal pneumoconiosis). Dr. Baker provided no explanation or rationale as to how he was able to attribute coal mine dust as a factor in these conditions. Moreover, at his deposition he was equivocal over his diagnosis of progressive massive fibrosis. For these reasons, I accord the opinion of Dr. Baker less weight.

I accord greater weight to the opinions of Drs. Jarboe and Dahhan. Their opinions are well-reasoned and consistent with the objective medical evidence, Claimant's medical history, physical examinations, smoking history, and symptoms. Dr. Jarboe found, consistent with this opinion, that pneumoconiosis was not present radiographically. He also concluded that Claimant's bullous emphysema was likely due to Claimant's 45 pack year history of smoking and that his restrictive impairment was due to old scarring. He convincingly explained that coal dust inhalation did not cause pleural disease, calcified plaques, or pleural plaques. Likewise, Dr. Dahhan opined Claimant did not have radiographic evidence of pneumoconiosis and that Claimant did not have any evidence of legal pneumoconiosis. Dr. Dahhan attributed Claimant's obstructive defect to smoking since it was responsive to bronchodilator therapy. Based on the foregoing, I find the opinions of Drs. Jarboe and Dahhan credible and more persuasive than the opinion of Dr. Baker.

Of record are the treatment notes of Drs. Fielder, Burrell, Hughes, and Bruton. DX 21. These physicians mention a diagnosis of pneumoconiosis or progressive massive fibrosis in their

notes without any discussion as to how Claimant was diagnosed with said condition or what information they relied on in making this determination. For this reason, I accord these treatment records less weight.

Accordingly, based on the foregoing, I find Claimant's has failed to establish, by the preponderance of the evidence, the existence of pneumoconiosis pursuant to §718.202(a)(4).

Cause of Pneumoconiosis Pursuant to 718.203

Once it is determined that the miner suffers from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment.

I find that Claimant, with 15 years of coal mine employment, would be entitled to the rebuttable presumption at §718.203. However, because Claimant failed to establish the existence of pneumoconiosis, this element is moot.

Evidence of Total Disability

A miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner from performing his usual coal mine work or comparable employment. §718.204(b)(1). Section 718.204 sets out the standards for determining total disability. This section provides that in the absence of contrary probative evidence, evidence that meets the quality standards of the subsection shall establish the miner's total disability.

Subsection 718.204(b)(2)(i) provides that total disability may be established by pulmonary function testing. Of the newly submitted evidence, there are three (3) pulmonary function studies submitted as part of Claimant's claim for benefits. None produced qualifying values. Since all of the studies produced non-qualifying values, I find that Claimant has failed to establish total disability due to §718.204(b)(2)(i).

Subsection 718.204(b)(2)(ii) provides that qualifying arterial blood gas testing may establish total disability. Of the newly submitted evidence, there are four (4) arterial blood gas studies in the record. Only the 5-3-04 arterial blood gas study produced qualifying values. Because the preponderance of the studies produced non-qualifying values, I find that Claimant has failed to establish total disability pursuant to §718.204(b)(2)(ii).

There is no evidence that the Claimant suffers from cor pulmonale with right-sided congestive heart failure pursuant to §718.204(b)(2)(iii).

Subsection 718.204(b)(2)(iv) provides that total disability may be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concluded that Claimant's respiratory or pulmonary impairment prevents him from engaging in his usual coal mine work or in comparable and gainful employment.

Of the newly submitted evidence, there are three (3) physicians who rendered an opinion in this matter relative to this issue. Drs. Dahhan and Baker opined Claimant was not totally disabled. Dr. Jarboe opined Claimant was totally disabled from performing his last coal mine employment.

Based on information contained within the medical reports, Claimant's last coal mine job was as a shuttle car operator in an underground coal mine. Claimant did not give testimony at the hearing regarding the exertional requirements of the job. However, I will consider

Claimant's last coal mine job to have included heavy labor for at least a portion of the work day in making my determination under this section.

I accord greater weight to the highly qualified opinions of Drs. Dahhan and Baker on this issue. I find that their respective opinions are well-reasoned and well-documented and are consistent with the objective diagnostic tests that showed the presence of only a mild obstructive impairment, Claimant's symptoms, medical history, the exertional requirements of Claimant's last coal mine employment, and smoking history. I also find credible and convincing Dr. Dahhan's opinion that Claimant had no significant abnormality in his ability to oxygenate his blood. For these reasons, I accord the opinions of Drs. Dahhan and Baker greater weight.

Conversely, I accord less weight to the opinion of Dr. Jarboe on this issue. In his medical report he opined that Claimant was totally disabled based at least in part on a severely reduced diffusing capacity. However, at his deposition, Dr. Jarboe reviewed additional pulmonary function studies and noted that Dr. Dahhan's vent study showed only a mildly reduced diffusion capacity. He also admitted that Claimant's resting arterial blood gases were essentially normal. These admissions reasonably cast doubt on the foundation for Dr. Jarboe's opinion that Claimant was totally disabled by his lung condition. Therefore, I accord the opinion of Dr. Jarboe less weight on this issue.

Based on the newly submitted medical opinion evidence, I find Claimant has failed to establish total disability within the meaning of §718.204(b)(2)(iv).

In weighing all of the foregoing, I find Claimant has failed to establish the existence of a totally disabling respiratory impairment pursuant to §718.204(b).

Disability Causation

The final issue is whether Claimant has established disability causation at Section 718.204(c)(1).

Pursuant to §718.204(c)(1) a miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis…is a substantially contributing cause of the miner's totally disabling respiratory impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:

(i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or

(ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

Because Claimant failed to establish the existence of pneumoconiosis and the existence of a totally disabling pulmonary impairment, this element is moot.

Subsequent Claim

Because Claimant has failed to establish an element of entitlement previously denied, I find Claimant has failed to establish a material change in conditions based on the newly submitted medical evidence.

Conclusion

Because Claimant has failed to establish all elements of entitlement, I must conclude that he is not entitled to benefits under the Act.

Attorneys Fee

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for representation services rendered in pursuit of the claim.

ORDER

The claim of **ANDY J. ADKINS** for black lung benefits under the Act is hereby **DENIED**.

A

DANIEL F. SOLOMON
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).